

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH

1913

County St. Marys

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 284

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Mechanicsville Ind

2 FULL NAME John Edward Barber

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Male Negro Single

6 DATE OF BIRTH

Feb. 17th, 1914
(Month) (Day) (Year)

7 AGE

yrs. mos. 7 ds. If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work. None
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

St. Marys Co

10 NAME OF FATHER

Lewis E. Barber

11 BIRTHPLACE OF FATHER

(State or country)

St. Marys Co

12 MAIDEN NAME OF MOTHER

Grace Stevens

13 BIRTHPLACE OF MOTHER

(State or country)

St. Marys Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lewis Barber

(Address) Mechanicsville

15

Filed Feb 24th 1914 Z. R. Morgan

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb. 24th, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

191... to 191... 191...

that I last saw h..... alive on 191... 191...

and that death occurred on the date stated above, at m.,

The CAUSE OF DEATH* was as follows:

I never saw the
child.

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Z. R. Morgan, M. D.
Feb 24th, 1914 (Address) Mechanicsville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) WHETHER ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

St. Calvary Cemetery Feb 25th, 1914

20 UNDERTAKER ADDRESS

Lewis Barber Mechanicsville

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

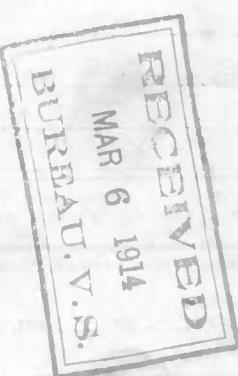
Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*,

"oma, Sarcoma, etc. of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sensus, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH		1914
County	St. Marys	
Village or City	St. Georges (No.)	
2 FULL NAME Jacob Buchanan		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED
Male	Negro	Married (Write the word)
6 DATE OF BIRTH		
Nov.	20	1847
(Month) (Day)		(Year)
7 AGE	66 yrs. 3 mos. 1 ds.	If LESS than 1 day, ____ hrs. OR ____ min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work		
Farm Laborer		
(b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country)		
Maryland!		
PARENTS		
10 NAME OF FATHER	Jacob Buchanan	
11 BIRTHPLACE OF FATHER (State or country)	Maryland!	
12 MAIDEN NAME OF MOTHER	Moses Reedey	
13 BIRTHPLACE OF MOTHER (State or country)	Maryland!	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE		
(Informant)	Stephen Clegg	
(Address)	St. Georges	
15 Filed	Feb. 23, 1914 E. T. Loyd	
REGISTRAR		

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 280

St.: Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 21, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from
Feb. 16, 1914, to Feb. 21, 1914,

that I last saw him alive on Feb. 21, 1914,

and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Foxenemia & Ex haemorrhage

(Duration) yrs. mos. 2 ds.
Contributory Secondary Loban P Neumonia

(Duration) yrs. mos. 6 ds.
(Signed) Stephen Clegg, M.D.

Feb. 23, 1914 (Address) St. Georges

*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place 66 yrs. 3 mos. 1 ds. in the State 66 yrs. 3 mos. 1 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St. Michaels
DATE OF BURIAL Feb. 23, 1914

20 UNDERTAKER E. Robinson
ADDRESS St. Georges

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Pianist*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*; (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Labourer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Træmnia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 1915
 County St. Marys
 Village or City Chapin

STATE OF MARYLAND
 CERTIFICATE OF DEATH

Registration Dist. No. 283

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Appie Elizabeth Buckler

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE White
 female

5 SINGLE,
 MARRIED,
 WIDOWED,
 OR DIVORCED
 (Write the word) single

6 DATE OF BIRTH

Sept. 21, 1913
 (Month) (Day) (Year)

7 AGE

yrs. 4 mos. 16 ds. If LESS than
 1 day, hrs.
 OR min.?

8 OCCUPATION

(a) Trade, profession, or
 particular kind of work.
 (b) General nature of industry,
 business, or establishment to
 which employed (or employer) —

9 BIRTHPLACE
 (State or country)

Chapin

10 NAME OF
 FATHER

Isah Buckler

11 BIRTHPLACE
 OF FATHER
 (State or country)

Mary Lane

12 MAIDEN NAME
 OF MOTHER

Agnes Gipps

13 BIRTHPLACE
 OF MOTHER
 (State or country)

Mary Lane

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(informant) Joseph Swade

(Address) Harry, Md.

15

Filed Feb. 21, 1914 Geor. Harmon

Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb. 21, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Feb. 18, 1914, to Feb. 18, 1914,
 that I last saw h..... alive on Feb. 18, 1914,

and that death occurred on the date stated above, at 3 a.m.
 The CAUSE OF DEATH* was as follows:

Suppurative carbuncle

(Duration) yrs. mos. ds.
 Contributory (Secondary) Bronchitis

(Duration) yrs. mos. ds.
 (Signed) Walter P. Dent, M.D.

Feb. 21, 1914 (Address) Oakley Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

St. Joseph Cemetery Feb. 21, 1914

20 UNDERTAKER Local Ass

DATE OF BURIAL

ADDRESS

Chapin

REVISED UNITED STATES STANDARD

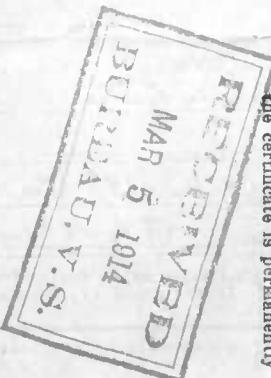
CERTIFICATE OF DEATH

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*; *Carcin-*oma. *Sarcoma*, etc., of (name origin); "Can-
cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-genital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mara-nus," "Old Age," "Shock," "Tetraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septic-emia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH
County St. Marys 1916

Village or City Bearwood (No.)

2 FULL NAME Infant Combs

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 282

St; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) <u>—</u>
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6 DATE OF BIRTH

Feb 8, 1914
(Month) (Day) (Year)

7 AGE

— yrs. — mos. — ds. It LESS than
1 day, — hrs.
OR — min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work —

(b) General nature of industry,
business, or establishment in
which employed (or employer) —

9 BIRTHPLACE
(State or country)

10 NAME OF
FATHER

11 BIRTHPLACE
OF FATHER
(State or country)

12 MAIDEN NAME
OF MOTHER

13 BIRTHPLACE
OF MOTHER
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed Feb 15, 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb 14, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Feb 8, 1914 to Feb 14, 1914
that I last saw him alive on Feb 13, 1914

and that death occurred on the date stated above, at _____.

The CAUSE OF DEATH* was as follows:

Mumps

(Duration) yrs. — mos. — ds.

Contributory (Secondary) Subacute Diphtheria

Mother (Duration) yrs. — mos. — ds.

(Signed) H. G. Greenwell, M. D.

Feb 15, 1914 (Address) Leonardtown

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place — yrs. — mos. — ds. In the — State — yrs. — mos. — ds.

Where was disease contracted,
if not at place of death?

Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

Our Lady's Chapel DATE OF BURIAL
Feb 15, 1914

20 UNDERTAKER

W. G. Mattock ADDRESS Leonardtown

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc. *Carcinoma*, *Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Athetia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital"), "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the Injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
MAR 6 1914
BUREAU, V.S.

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1 PLACE OF DEATH

1917

County

St. Mary's

Village or City

St. Georges

2 FULL NAME

Sylvia Dyson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Negro

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Widow

6 DATE OF BIRTH

X (Month) (Day) (Year)

7 AGE

100 yrs. mos. ds. If LESS than
1 day, hrs. OR min.?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work

Housewife

(b) General nature of industry,
business, or establishment in
which employed (or employer)9 BIRTHPLACE
(State or country)

Maryland

PARENTS

10 NAME OF
FATHER

John Dyson

11 BIRTHPLACE
OF FATHER
(State or country)

Maryland

12 MAIDEN NAME
OF MOTHER

Phyllis Clark

13 BIRTHPLACE
OF MOTHER
(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. R. Clegg

(Address)

St. Georges

15

Filed Feb 27, 1917

O. H. Leoyd
REGISTRARSTATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 280

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

St.: Ward)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb.

26

, 1917

(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from
Feb 12, 1917, to Feb. 26, 1917,that I last saw her alive on Feb. 26, 1917,
and that death occurred on the date stated above, at 2 p.m.
The CAUSE OF DEATH* was as follows:Suffocation
ExhaustionSenile Decay
(Duration) yrs. 3 mos. 3 ds.Contributory
Secondary
Senile Decay
(Duration) yrs. 8 mos. 3 ds.(Signed) Stephen Clegg, M. D.
Feb 27, 1917 (Address) St. Georges*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCI-
DENTAL, SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place 100 yrs. mos. ds. In the State 100 yrs. mos. ds.

Where was disease contracted,
If not at place of death?Former or
usual residence.

19 PLACE OF BURIAL, OR REMOVAL

St. Georges

DATE OF BURIAL
Feb 27, 1917

20 UNDERTAKER

E. Robinson

ADDRESS
Post Office

REVISED UNITED STATES STANDARD

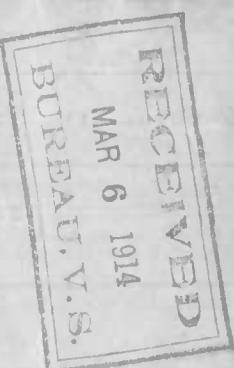
CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Pianist*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic arteriolar heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is locked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH

1918

County St. Mary'sVillage or City River Spring (No. 15)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 286St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME William Dyer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>Edmed</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)	<u>Single</u>
6 DATE OF BIRTH <u>1</u>		19	, 1914 (Month) (Day) (Year)
7 AGE <u>yrs. 18 mos. 18</u>		If LESS than 1 day, _____ hrs. OR min. ?	

8 OCCUPATION <u>lumber</u>		(a) Trade, profession, or particular kind of work.
		(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) <u>Ind</u>		10 NAME OF FATHER <u>William Dyer</u>
11 BIRTHPLACE OF FATHER (State or country) <u>Ind</u>		12 MAIDEN NAME OF MOTHER <u>Almena Jefferson</u>
13 BIRTHPLACE OF MOTHER (State or country) <u>Ind</u>		

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Henrietta Jefferson</u>	
(Address) <u>River Spring</u>	

15 Filed <u>3-1-4</u>	By <u>Robert Palmer</u>
-----------------------	-------------------------

REGISTRAR -

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 2-6-1914

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

2-1-1914 to 2-6-1914that I last saw him alive on 2-6-1914and that death occurred on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Actions Physiological

(Duration) yrs. mos. ds.

Contributory
(Secondary) Indemnity

(Duration) yrs. mos. ds.

(Signed) Robert Palmer, M. D.3-1-1914 (Address) Palmer

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL all Cains DATE OF BURIAL 2-7-191420 UNDERTAKER Ginger Young ADDRESS River Spring

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

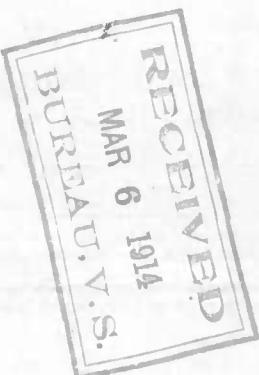
(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—Coal mining, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

oma

Sarcoma, etc. of _____ (name origin: "Can-
cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-
thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-
genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Maras-
tins," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septic-
mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH		1919	STATE OF MARYLAND CERTIFICATE OF DEATH	
County <i>S. J. Marys</i>		<i>Palmer</i>	Registration Dist. No. <i>286</i>	
Village or City <i>Palmer</i> (No.)		<i>Palmer</i>	St.:	Ward)
2 FULL NAME <i>Charles Alyx andrew ellis</i>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <i>male</i>	4 COLOR OR RACE <i>white</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>MARRIED</i>	MEDICAL CERTIFICATE OF DEATH	
6 DATE OF BIRTH <i>9. 9. 1854</i>		If LESS than 1 day, _____ hrs. OR min. ?	16 DATE OF DEATH <i>2. 25. 1914</i>	(Month) (Day) (Year)
7 AGE <i>59 yrs. 5 mos. 16 ds.</i>			17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,	that I last saw him alive on _____, 191____,
8 OCCUPATION <i>Oysterman</i>		and that death occurred on the date stated above, at <i>9 P.M.</i>		
(a) Trade, profession, or particular kind of work.		<i>Cerebral Apoplexy</i>		
(b) General nature of industry, business, or establishment in which employed (or employer)				
9 BIRTHPLACE (State or country) <i>Md</i>		(Duration) <i>yrs. mos. ds.</i>		
10 NAME OF FATHER <i>John Nelson Ellis</i>		Contributory (Secondary) <i>Suicide</i>		
11 BIRTHPLACE OF FATHER (State or country) <i>Md</i>		(Duration) <i>yrs. mos. ds.</i>		
12 MAIDEN NAME OF MOTHER <i>Unknown</i>		(Signed) <i>P. M. V. Palmer</i> , M. D.		
13 BIRTHPLACE OF MOTHER (State or country) <i>Md</i>		2-27-1914 (Address) <i>Palmer</i>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Virginia Ellis</i>				
(Address) <i>Palmer Md</i>				
15 Filed <i>3-1-1914 P. M. Palmer</i>		18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <i>yrs. mos. ds.</i> In the State <i>yrs. mos. ds.</i>		
Where was disease contracted, if not at place of death?				
Former or usual residence.				
16 PLACE OF BURIAL OR REMOVAL <i>all claims</i>		19 PLACE OF BURIAL OR REMOVAL <i>all claims</i>		
20 UNDERTAKER <i>Eugene Hall</i>		DATE OF BURIAL <i>2-28-1914</i>		
ADDRESS <i>Lyman</i>				

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

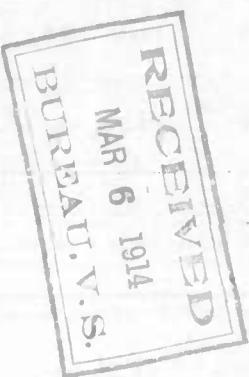
(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Servant*, *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma

Sarcoma, etc. of (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mara-nus," "Old Age," "Shock," "Uratemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train*—accident; *Revolver wound of head*—homicide; *Poisoned by carbolic acid*—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH		1920
County	St. Mary's	
Village or City	Leonardtown	
2 FULL NAME Infant Goode		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Male	Colored	Single
6 DATE OF BIRTH		
Feb 28 th , 1914		
(Month) (Day) (Year)		
7 AGE		
yrs.	mos. 23	ds. 0
If LESS than 1 day, _____ hrs. OR _____ min. ?		
8 OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer)		
Infant		
9 BIRTHPLACE (State or country)		
Md		
10 NAME OF FATHER		
Clarence Goode		
11 BIRTHPLACE OF FATHER (State or country)		
So. Carolina		
12 MAIDEN NAME OF MOTHER		
Annie Rau		
13 BIRTHPLACE OF MOTHER (State or country)		
Va.		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE		
(Informant) Clarence Goode		
(Address) Leonardtown Md.		
15		

Filed....., 191.....

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 282

St. Ward

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb 28, 1914

(Month) (Day) (Year)

17 I HEREBY CERTIFY, THAT I attended deceased from

Feb 25, 1914, to Feb 28, 1914,

that I last saw him alive on Feb 28, 1914,

and that death occurred on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Infection

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Frank J. Canale, M.D.

Feb 28, 1914 (Address) Leonardtown Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

Leonardtown Md. Feb 28, 1914

DATE OF BURIAL

20 UNDERTAKER

Dennis Chamberlain Leonardtown

ADDRESS

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease

causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Group"); Typhoid fever (never report "Typhoid pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc. Cancer-

oma, Sarcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERAL septicæmia," "PUERAL peritonitis," etc. State cause for accidental, suicidal, or homicidal, or as probably as such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH		1921
County	St. Marys	
Village or City	Hollywood (No.)	
2 FULL NAME		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Female	white	single
6 DATE OF BIRTH		
Feb. 26, 1914 (Month) (Day) (Year)		
7 AGE	If LESS than 1 day.....hrs. 0 yrs. 0 mos. 0 ds. OR min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in which employed (or employer).....		
None		
9 BIRTHPLACE (State or country)		
St. Marys Co.		
10 NAME OF FATHER		
Jos. C. Goodwin		
11 BIRTHPLACE OF FATHER (State or country)		
Md.		
12 MAIDEN NAME OF MOTHER		
Clue E. Farwell		
13 BIRTHPLACE OF MOTHER (State or country)		
Md.		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE		
(Informant) Jos. C. Goodwin		
(Address) Hollywood, Md.		
15	Filed 191	

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 283

St. Ward

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 26, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

, 191..., to , 191...

that I last saw h..... alive on , 191...

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Still Born

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Jos. C. Miller Local Rtg., M.D.
Feb 26, 1914 (Address) Hollywood, Md.* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCI-
DENTAL, SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St John's Cemetery Feb 27, 1914

20 UNDERTAKER ADDRESS

Jos. C. Goodwin Hollywood

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

BUREAU, V.S.

RECEIVED
MAR 6 1914

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Houseworker*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenic," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH St. Georges
County, Maryland 1922

Village or City St. Georges (No.)

2 FULL NAME Bernard Green

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male	4 COLOR OR RACE Nigro	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single
----------------------	---------------------------------	--

6 DATE OF BIRTH
Mar., 1913
(Month) (Day) (Year)

7 AGE
yrs. 11 mos. da. OR min. ?
It LESS than
1 day, hrs.
or min. ?

8 OCCUPATION
(a) Trade, profession, or
particular kind of work.
(b) General nature of industry,
business, or establishment in
which employed (or employer)

9 BIRTHPLACE
(State or country) Md

10 NAME OF FATHER
Jeremiah Green

11 BIRTHPLACE OF FATHER
(State or country) Md

12 MAIDEN NAME OF MOTHER
Celia Biscoe

13 BIRTHPLACE OF MOTHER
(State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jeremiah Green
(Address) St. Georges

15
Filed Feb. 28, 1914
By W. Lloyd

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 280

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

St. Ward)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 25, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, THAT I attended deceased from
Feb. 23, 1914, to Feb. 25, 1914,
that I last saw him alive on Feb. 25, 1914,
and that death occurred on the date stated above, at 8 a.m.
The CAUSE OF DEATH* was as follows:

Bronchitis Acute
(Duration) yrs. mos. 65 ds.

Contributory
Secondary

(Signed) Stephen Clegg, M. D.
Feb. 25, 1914 (Address) St. Georges

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. da. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, OR REMOVAL St. Georges

DATE OF BURIAL Feb. 26, 1914

20 UNDERTAKER Jeremiah Green

ADDRESS St. Georges

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is Indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Masstes*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicæmia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See Instructions on back of certificate.

PLACE OF DEATH		1922
County	St. Marys Co.	
Village or City	Mechanicsville	
Street	Main Street	
FULL NAME Eddie Bone child		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED
Boy	Colored	Single
6 DATE OF BIRTH		
Feb	46	1914
(Month)	(Day)	(Year)
7 AGE	8 OCCUPATION	
Eddie Bone	none	(a) Trade, profession, or particular kind of work
Yrs. mos. ds.	Or min. ?	(b) General nature of industry, business, or establishment in which employed (or employer)
9 BIRTHPLACE (State or country)		
St. Mary's Co.		
PARENTS		
10 NAME OF FATHER	Jos. S. Hardy	
11 BIRTHPLACE OF FATHER (State or country)	St. Mary's Co.	
12 MAIDEN NAME OF MOTHER	Henrietta Holey	
13 BIRTHPLACE OF MOTHER (State or country)	St. Mary's Co.	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE		
(Informant)	Jos. S. Hardy	
(Address)	Mechanicsville, Md.	
15	Filed Feb. 5 th , 1914 Zact. R. Morgan	
REGISTRAR		

STATE OF MARYLAND CERTIFICATE OF DEATH		
Registration Dist. No.	284	
St. Hospital	Ward	
If death occurred in hospital or institution, give its NAME instead of street and number.]		
MEDICAL CERTIFICATE OF DEATH		
16 DATE OF DEATH	Feb. 1 st , 1914	
(Month)	(Day)	(Year)
17 I HEREBY CERTIFY, That I attended deceased from		
, 1914, to , 1914,		
that I last saw him alive on , 1914,		
and that death occurred on the date stated above, at m.		
The CAUSE OF DEATH* was as follows:		
Preservative Labor		
(Duration) yrs. mos. ds.		
Contributory Secondary		
(Duration) yrs. mos. ds.		
(Signed) Zact. R. Morgan, M. D.		
Feb. 5 th , 1914. (Address) Mechanicsville, Md.		
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)		
At place	In the	
of death yrs. mos. ds.	State	yrs. mos. ds.
Where was disease contracted, if not at place of death?		
Former or usual residence.		
19 PLACE OF BURIAL OR REMOVAL		
St. Joseph's Cemetery		DATE OF BURIAL
20 UNDERTAKER		ADDRESS
Jos. S. Hardy		Mechanicsville

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*; (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

MAR 6 1914

BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <i>St. Mary's</i>		1924	STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <i>Abes</i> (No.)			Registration Dist. No. <i>286</i>		
2 FULL NAME <i>Marguerite Edna Smith</i>			St. <i>Ward</i>)		
[If death occurred in a hospital or institution, give its NAME instead of street and number.]					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <i>Female</i>	4 COLOR OR RACE <i>white</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>Individ</i>	MEDICAL CERTIFICATE OF DEATH		
6 DATE OF BIRTH <i>1 - 27 - 1899</i>		7 AGE <i>22 yrs. 1 mos. - ds.</i>	16 DATE OF DEATH <i>2 - 22 - 1914</i>	(Month) (Day) (Year)	
		If LESS than 1 day, hrs. OR min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work. <i>None</i>		I HEREBY CERTIFY, That I attended deceased from <i>2 - 22 - 1914</i> , to <i>2 - 22 - 1914</i>			
(b) General nature of industry, business, or establishment to which employed (or employer) <i>None</i>		that I last saw h.e. alive on <i>2 - 26 - 1914</i>			
9 BIRTHPLACE (State or country) <i>Individ</i>		and that death occurred on the date stated above, at <i>4 a.m.</i> The CAUSE OF DEATH* was as follows:			
10 NAME OF FATHER <i>Cullins</i>		<i>Influenza</i>			
11 BIRTHPLACE OF FATHER (State or country) <i>Individ</i>		(Duration) <i>6 days</i>			
12 MAIDEN NAME OF MOTHER <i>Gordon</i>		Contributory (Secondary) <i>Effusion</i>			
13 BIRTHPLACE OF MOTHER (State or country) <i>Individ</i>		(Duration) <i>14 days</i>			
(Signed) <i>Ross Palmer</i> M. D.					
228-1914 (Address) <i>Baltimore Palmerwood</i>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
14 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)					
At place of death yrs. mos. ds. In the State yrs. mos. ds.					
Where was disease contracted, if not at place of death?					
Former or usual residence					
15 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Marion Hill</i> (Address) <i>Abes Individ</i>					
16 PLACE OF BURIAL OR REMOVAL Filed <i>3-1-1914 Ross Palmer</i>					
DATE OF BURIAL <i>3-1-1914</i>					
17 UNDERTAKER <i>John W. Clegg</i>					
ADDRESS <i>Chaptico</i>					
If more blanks are needed, address State Registrar, 6 E. Franklin St., Baltimore, Requesting V. S. No. 1.					

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

oma

Sarcoma, etc., or _____ (name origin: "Can-
cer" is less definite; avoid use of "Tumor" for malignant
neoplasms); *Measles*; *Whooping cough*; *Chronic
tubular heart disease*; *Chronic interstitial nephritis*,
etc. The contributory (secondary or intercurrent)
affection need not be stated unless important. Ex.
ample: *Miscles* (disease causing death), *29 d.*; *Bronchopneumonia* (secondary), *10 d.* Never report
mere symptoms or terminal conditions, such as "As-
thenia," "Anæmia" (merely symptomatic), "Atrophy,"
"Collapse," "Coma," "Convulsions," "Debility" ("Con-
genital"), "Senile," etc.), "Dropsy," "Exhaustion,"
"Heart failure," "Haemorrhage," "Inanition," "Marns-
ius," "Old Age," "Shock," "Uraemia," "Weakness,"
etc., when a definite disease can be ascertained as the
cause. Always qualify all diseases resulting from
childbirth or miscarriage, as "Puerperal septicar-
mia," "Puerperal peritonitis," etc. State cause for
which surgical operation was undertaken. For vi-
olent deaths state means of injury and quality as
ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably*
such, if impossible to determine definitely. Examples:
Accidental drowning; *Struck by railway train—accident*;
Revolver wound of head—homicide; *Poisoned
by carbolic acid—probably suicide*. The nature of the
injury, as fracture of skull, and consequences (e. g.,
sepsis, *tetanus*) may be stated under the head of
"Contributory." (Recommendations on statement of
cause of death approved by Committee on Nomencla-
ture of the American Medical Association.)

If this certificate is looked over thoroughly and all ques-
tions answered in detail, it will prevent further correspond-
ence. All the data is essential and must be obtained before
the certificate is permanently filed.

RECEIVED

MAR 6 1914

BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

1925

County *H. Maryland*STATE OF MARYLAND
CERTIFICATE OF DEATHRegistered No. *282*Village or City *Leonardtown* (No.)

St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *Infant Jones*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Female</i>	4 COLOR OR RACE <i>white</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>—</i>
6 DATE OF BIRTH <i>Feb 3, 1914</i> (Month) (Day) (Year)		
7 AGE <i>Stillborn</i> yrs. mos. ds.		
If LESS than 1 day, ... hrs. OR min. ?		

8 OCCUPATION (a) Trade, profession, or particular kind of work. <i>—</i>
(b) General nature of industry, business, or establishment in which employed (or employer) <i>—</i>

9 BIRTHPLACE (State or country) <i>H. Maryland</i>

10 NAME OF FATHER <i>Edgar S. Jones</i>
11 BIRTHPLACE OF FATHER (State or country) <i>H. Maryland</i>
12 MAIDEN NAME OF MOTHER <i>Annis G. Alvey</i>
13 BIRTHPLACE OF MOTHER (State or country) <i>H. Maryland</i>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Edgar S. Jones</i>
(Address) <i>Leonardtown</i>

15 Filed <i>Feb 4, 1914</i> by <i>J. F. Greenwell</i>

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Stillborn Feb 3, 1914*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from
..... 191 ..., to 191 ...,
that I last saw h. alive on 191 ...,
and that death occurred on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Breach delivery
(Duration) yrs. mos. ds.

Contributory (Secondary) *Placenta Previa in Juxta*
(Duration) yrs. mos. ds.
(Signed) *J. F. Greenwell*, M. D.
Feb 4, 1914 (Address) *Leonardtown Md*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Rich Duck Farm*
DATE OF BURIAL *Feb 5, 1914*

20 UNDERTAKER *Edgar S. Jones*
ADDRESS *Leonardtown*

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Associated] American Public Health

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Saleman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.; *Carcin-* *oma*, *Sarcoma*, etc., of (name origin; "Can-
cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Ab-
stinenza," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-
genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mara-
mus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scaphis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
MAR 6 1914
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH		1926
County		Mary
Village or City		Valley Lee
2 FULL NAME		Mary Virginia Mason
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
female	colored.	single
6 DATE OF BIRTH		
September 15, 1898		
(Month) (Day) (Year)		
7 AGE	If LESS than 1 day, hrs. OR min. ?	
15 yrs. 5 mos. 7 ds.		
8 OCCUPATION		
(a) Trade, profession, or particular kind of work.		
none		
(b) General nature of industry, business, or establishment in which employed (or employer)		
none		
9 BIRTHPLACE (State or country)		
St. Marys Co. Md.		
10 NAME OF FATHER		
unknown		
11 BIRTHPLACE OF FATHER (State or country)		
unknown		
12 MAIDEN NAME OF MOTHER		
Alice Mason		
13 BIRTHPLACE OF MOTHER (State or country)		
St. Marys Co. Md.		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE		
Informant	Mary Virginia Mason	
(Address)	Valley Lee, Md.	
15		
Filed	March 1, 1914	
	Benj. F. Redman	
	REGISTRAR	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

33

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 281

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH February 27, 1914
(Monthly) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1912, to Feb. 27, 1914, that I last saw her alive on Dec. 12, 1913, and that death occurred on the date stated above, at 6 P.M.,

The CAUSE OF DEATH* was as follows:

Tuberculosis of hip joints

(Duration) yrs. mos. ds.

Contributory Nephritis
(Secondary)

(Duration) 2 yrs. mos. ds.

(Signed) C. A. Brown, M.D.
(Address) Red Gate, Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St. George Church Valley, Md., 1914
DATE OF BURIAL

20 UNDERTAKER James Jordan
ADDRESS Valley Lee, Md.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc. *Carcin-*

oma

Sarcoma, etc., of (name origin; "Ganglion" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

1927

County *St. Marys*Village or City *Lewisburg*STATE OF MARYLAND
CERTIFICATE OF DEATHRegistered No. *282*

St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *Hannah E. Gilburn*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Female</i>	4 COLOR OR RACE <i>white</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>MARRIED</i> (Write the word)
---------------------	------------------------------	--

6 DATE OF BIRTH

Jan 18, 1858
(Month) (Day) (Year)

7 AGE

*50 yrs. 1 mos. 9 ds.*If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(informant) *Elizabetus Gilburn*(Address) *Lewisburg*

15

Filed *Feb 28, 1914**J. G. Greenwell*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Feb 27, 1914*
(Month) (Day) (Year)

17 I HEREBY CERTIFY. That I attended deceased from

*Mar., 1914, to Feb 27, 1914.*that I last saw her alive on *Feb 24, 1914*and that death occurred on the date stated above, at *1 a.m.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) *9 yrs. - mos. - ds.*Contributory
(Secondary)(Duration) *yrs. - mos. - ds.*(Signed) *J. G. Greenwell* M. D.(Address) *Lewisburg*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place *In the* In the
of death *yrs. mos. ds.* State *yrs. mos. ds.*Where was disease contracted,
if not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

Our Lady of Lourdes

20 UNDERTAKER

Wm. McMurtry

DATE OF BURIAL

Mar 2, 1914

ADDRESS

Lewisburg

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

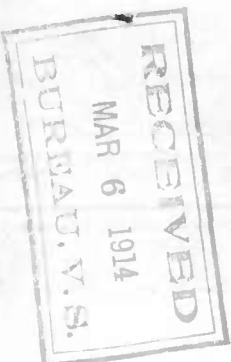
Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 dn.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Abortion," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malnutrition," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

1928

Village or City

Leonardtown

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 282

St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Francis Oscar Morgan

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

Jan. 29, 1855

(Month)

(Day)

(Year)

7 AGE

59

yrs.

mos.

29

ds.

If LESS than
1 day, ____ hrs.
OR ____ mts. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work.(b) General nature of industry,
business, or establishment in
which employed (or employer)

Merchant

9 BIRTHPLACE
(State or country)

Md

William J. Morgan

10 NAME OF
FATHER11 BIRTHPLACE
OF FATHER
(State or country)12 MAIDEN NAME
OF MOTHER13 BIRTHPLACE
OF MOTHER
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed _____, 1911.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb.

18th

(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

Feb. 7th, 1914, to Feb. 7th, 1914, 1914that I last saw him alive on Feb. 28th, 1914,

and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Alcohol Indigestion
Fatty Heart (Duration) yrs. mos. ds.Contributory
(Secondary)

Y (Duration) yrs. mos. ds.

(Signed) Francis J. Gauley, M.D.

Feb. 25th, 1914 (Address) Leonardtown, Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place _____ yrs. mos. ds. in the _____ State _____ yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence.

19 PLACE OF BURIAL OR REMOVAL

St. Alloysius Cemetery Mar. 2, 1914

20 UNDERTAKER W.C. Macraugh ADDRESS

Leonardtown, Md.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease

causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc.* *Carcin-*

oma

Sarcoma, etc., of _____ (name origin; "Can-
cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chro-
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genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraæmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Pueræral septicæmia," "Pueræral peritonitis," etc. State cause for which surgical operation was undertaken. For violent death state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

MAR 6 1914

BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County		1929	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City		Registration Dist. No. 787		
2 FULL NAME <i>Sarah Ann Morris</i>		St. _____ Ward _____		
[If death occurred in a hospital or institution, give its NAME instead of street and number.]				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <i>Female</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>Marius</i>	MEDICAL CERTIFICATE OF DEATH	
6 DATE OF BIRTH ? ?	1858 (Month) (Day) (Year)		16 DATE OF DEATH <i>Feb. 1st</i> , 1914 (Month) (Day) (Year)	
7 AGE <i>56</i>	11 LESS than 1 day, ____ hrs. OR ____ min. ?		I HEREBY CERTIFY, That I attended deceased from <i>Jan 30th</i> , 1914, to <i>Feb 1st</i> , 1914, that I last saw her alive on <i>Feb 1st</i> , 1914, and that death occurred on the date stated above, at 10 P.M. The CAUSE OF DEATH* was as follows:	
8 OCCUPATION (a) Trade, profession, or particular kind of work. <i>Housewife</i>			<i>Labor Precussions</i>	
9 BIRTHPLACE (State or country) <i>MD</i>			about (Duration) yrs. mos. ds.	
10 NAME OF FATHER <i>Thomas Abel</i>	Contributory (Secondary) <i>F. J. Gauvin & Son</i>		(Duration) yrs. mos. ds.	
11 BIRTHPLACE OF FATHER (State or country) <i>MD</i>			(Signature) <i>F. J. Gauvin & Son</i> , M.D.	
12 MAIDEN NAME OF MOTHER <i>Marta Morris</i>			(Address) <i>Leonardtown, Md.</i>	
13 BIRTHPLACE OF MOTHER (State or country) <i>MD</i>	*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Sarah Morris</i>	18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds.			
(Address) <i>Beaumar, Md.</i>	Where was disease contracted, if not at place of death? Former or usual residence.			
15	19 PLACE OF BURIAL OR REMOVAL <i>Medley's Field Cemetery, Feb. 3, 1914</i>		DATE OF BURIAL <i>Feb. 3, 1914</i>	
Filed _____, 1914	20 UNDERTAKER <i>A. C. Mattingly</i>		ADDRESS <i>Leonardtown, Md.</i>	
If more blanks are needed, address State Registrar, 8 E. Franklin St., Balt., Requesting V. S. No. 1.				

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.. *Carcinoma*. *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mumps*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
MAR 6 1914
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

1930

County St. Mary'sVillage or City Baltimore (No. 111)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 286St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Lillian Louise Duvens

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Sing</u> (Write the word)
---------------------	------------------------------	---

6 DATE OF BIRTH

6 1, 1911
(Month) (Day) (Year)

7 AGE

2 yrs. 6 mos. 2 ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)NoneInd

10 NAME OF FATHER

Giffith Duvens11 BIRTHPLACE OF FATHER
(State or country)

12 MAIDEN NAME OF MOTHER

Lula Duvens13 BIRTHPLACE OF MOTHER
(State or country)Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Giffith Duvens

(Address)

Baltimore Ind

15

Filed 3-1-1914 P.Walmer

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

2 2, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from
3-26-1914 to 2-2-1914,that I last saw her alive on 2-1-1914,and that death occurred on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) yrs. mos. 3 ds.Contributory
(Secondary)Pneumonia(Duration) yrs. mos. 7 ds.(Signed) P.W. Walmer, M. D.2-2-1914 (Address) Baltimore

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

Sacred Heart

DATE OF BURIAL

2-3-1914

20 UNDERTAKER

Hughes Hall

ADDRESS

Hughes Hall

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.. *Carcin-*

oma

Sarcoma, etc. of _____ (name origin: "Can-
cer" is less definite; avoid use of "Tumor" for malig-
nant neoplasms); *Measles*; *Whooping cough*; *Chronic
valvular heart disease*; *Chronic interstitial nephritis*,
etc. The contributory (secondary or intercurrent)
affection need not be stated unless important. Ex-
ample: *Measles* (disease causing death), 29 d.;
Bronchopneumonia (secondary), 10 d. Never report
mere symptoms or terminal conditions, such as "As-
thenia," "Anaemia" (merely symptomatic), "Aatrophy,"
"Collapse," "Coma," "Convulsions," "Debility" ("Con-
genital," "Senile," etc.), "Dropsy," "Exhaustion,"
"Heart failure," "Haemorrhage," "Inanition," "Mara-
inus," "Old Age," "Shock," "Uraemia," "Weakness,"
etc., when a definite disease can be ascertained as the
cause. Always qualify all diseases resulting from
childbirth or miscarriage, as "Puerperal septicæ-
mia," "Puerperal peritonitis," etc. State cause for
which surgical operation was undertaken. For vio-
lent deaths state means of injury and qualify as
ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably*
such, if impossible to determine definitely. Examples:
Accidental drowning; *Struck by railway train—acci-
dent*; *Revolver wound of head—homicide*; *Poisoned
by carbolic acid—probably suicide*. The nature of the
injury, as fracture or skull, and consequences (e. g.,
sepsis, *tetanus*) may be stated under the head of
"Contributory." (Recommendations on statement of
cause of death approved by Committee on Nomencla-
ture of the American Medical Association.)

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tions answered in detail, it will prevent further correspond-
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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 1931

County St. Marys

Village or City near Charlotte Hall (No. 104)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 234

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Rosina Estelle Plesler

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female	4 COLOR OR RACE colored	5 SINGLE, MARRIED, WIDOWED, DIVORCED (Write the word) Married
--------------	-------------------------	--

6 DATE OF BIRTH

Born Jan. - month / 1870
(Month) (Day) (Year)

7 AGE

44 yrs. mos. ds. If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work House work
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

St. Marys Co.

10 NAME OF FATHER

Alfred Tolson

11 BIRTHPLACE OF FATHER
(State or country)

St. Marys Co.

12 MAIDEN NAME OF MOTHER

Maria Bush

13 BIRTHPLACE OF MOTHER
(State or country)

St. Marys Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rosina Plesler

(Address) Charlotte Hall

15

Feb. 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 4, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Feb. 1st, 1914, to Feb. 3rd, 1914

that I last saw her alive on Feb. 3rd, 1914

and that death occurred on the date stated above, at 11:45 P.m.

The CAUSE OF DEATH* was as follows:

Aphoplexy

(Duration) yrs. mos. 4 ds.

Contributory
(Secondary) Exanthem

(Duration) yrs. mos. ds.

(Signed) Sam'l. Johnson, M. D.
Feb. 6th, 1914 (Address) Charlotte Hall

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Ebenezer Church, St. Marys Co. Feb. 6th, 1914

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Sydney Dent Du Bois
Charles St. 700

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma*, *Sarcoma*, etc. of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scaphis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
MAR 6 1914
DEPT. OF U. S. CENSUS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

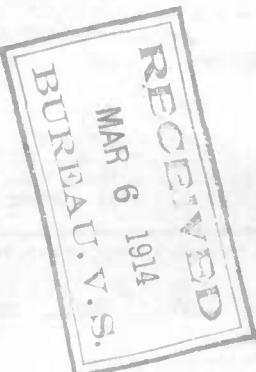
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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid pneumonia"); Lobar pneumonia; Bronchopneumonia (Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritonaeum, etc.. Cancer.

Oma, Sarcoma, etc. of (name origin: "Car-
jer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-
thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-
genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Maras-
mus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicach-
mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH . 1933
County St. Marys

Village or City St. Georges (No.)

2 FULL NAME

Brady Spicer.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male	4 COLOR OR RACE Negro	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single (Write the word)
------------	-----------------------	--

6 DATE OF BIRTH

July 1, 1912
(Month) (Day) (Year)

7 AGE

1 yrs. 7 mos. 16 ds. If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work X None
(b) General nature of industry, business, or establishment in which employed (or employer) X

9 BIRTHPLACE

(State or country)

Maryland
Wilson Spicer

PARENTS

10 NAME OF FATHER

Wilson Spicer

11 BIRTHPLACE OF FATHER

(State or country)

Maryland.

12 MAIDEN NAME OF MOTHER

Emma Medley

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Stephen Crowe M.D.
(Address) St. Georges

15 MELIO BENEDICT Barnes
FILED

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 280

89

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

St. Ward)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb. 16, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Feb. 15th, 1914, to

that I last saw him alive on Feb. 15th, 1914,

and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Typhemia & Exhaustion

(Duration) yrs. mos. 2 ds.
Contributory Secondary Exacerbation Bronchitis

(Signed) Stephen Crowe, M.D.
Feb. 17, 1914 (Address) St. Georges

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 7 mos. 16 ds. In the State 1 yrs. 7 mos. 16 ds

Where was disease contracted, if not at place of death? X

Former or usual residence X

19 PLACE OF BURIAL OR REMOVAL

St. Georges
February 18, 1914

DATE OF BURIAL

Feb. 18, 1914

20 UNDERTAKER

Benedict Barnes St. Georges

ADDRESS

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

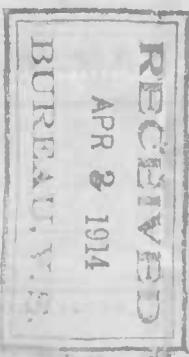
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer*,

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malasmus," "Old Age," "Shock," "Tetraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably*, such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., scrosis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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* PLACE OF DEATH

1934

County *St. Marys Co.*Village or City *Garrison* (No.)

* FULL NAME

*Robert Summersville*STATE OF MARYLAND
CERTIFICATE OF DEATHRegistered No. *282*

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
<i>Male</i>	<i>colored</i>	<i>widow</i>

6 DATE OF BIRTH		
<i>not known</i>		
(Month)	(Day)	(Year)

7 AGE		
<i>83</i>	— yrs.	mos. — ds.
If LESS than 1 day, ... hrs. OR min. ?		

8 OCCUPATION		
(a) Trade, profession, or particular kind of work... <i>Farm Labourer</i>		
(b) General nature of industry, business, or establishment in which employed (or employer)		

9 BIRTHPLACE (State or country)		
<i>St. Marys Co.</i>		

10 NAME OF FATHER		
<i>not known</i>		

11 BIRTHPLACE OF FATHER (State or country)		
<i>not known</i>		

12 MAIDEN NAME OF MOTHER		
<i>not known</i>		

13 BIRTHPLACE OF MOTHER (State or country)		
<i>not known</i>		

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE		
<i>John D. Summersville</i>		

(Informant)		
<i>John D. Summersville</i>		

(Address)		
<i>Garrison</i>		

15 Filed		
<i>Feb 13, 1914</i>		

REGISTRAR		
<i>J. F. Greenwell</i>		

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH	<i>Feb 12, 1914</i>
(Month)	<i>Feb</i>
(Day)	<i>12</i>
(Year)	<i>1914</i>

17 I HEREBY CERTIFY, That I attended deceased from	<i>Feb 12, 1914, to Feb 12, 1914,</i>
that I last saw him alive on	<i>July 1913</i>
and that death occurred on the date stated above, at	<i>9:30 AM</i>
The CAUSE OF DEATH* was as follows:	<i>Chronic nephritis</i>

(Duration)	<i>3 yrs. mos. ds.</i>
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Contributory (Secondary)	<i>Advanced Age</i>
--------------------------	---------------------

(Duration)	<i> yrs. mos. ds.</i>
------------	-----------------------

(Signed)	<i>J. F. Greenwell</i>
(Address)	<i>Garrison, Maryland</i>

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place	In the
of death	yrs. mos. ds.

Where was disease contracted,	State
If not at place of death?	yrs. mos. ds.

Former or	In the
usual residence	yrs. mos. ds.

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
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<i>Garrison cemetery</i>	<i>Feb 14, 1914</i>
--------------------------	---------------------

20 UNDERTAKER	ADDRESS
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<i>W. C. Mattingly</i>	<i>Garrison</i>
------------------------	-----------------

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

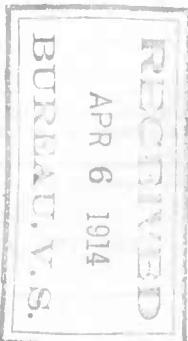
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*; *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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PLACE OF DEATH

County

1935

Village or City

St. Neary's

Compton

No.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 282

* FULL NAME

Budie Elizabeth Wathen

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

* SEX

Female

* COLOR OR RACE

white

* SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

married

* DATE OF BIRTH

Sept. 9th, 1989

(Month) (Day) (Year)

* AGE

24 yrs. 6 mos. 20 ds.

If LESS than
1 day, ____ hrs.
OR ____ min. ?

* OCCUPATION

(a) Trade, profession, or
particular kind of work.(b) General nature of industry,
business, or establishment in
which employed (or employer)

Housewife

* BIRTHPLACE
(State or country)

Md

PARENTS

10 NAME OF
FATHER

John D. Mattingly

Md

11 BIRTHPLACE
OF FATHER
(State or country)12 MAIDEN NAME
OF MOTHER

Mary E. Pope

Md

13 BIRTHPLACE
OF MOTHER
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. M. Yates

(Address)

Compton Md

15

Filed....., 191.....

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb. 19th, 1914

(Month) (day) (Year)

17 I HEREBY CERTIFY that deceased from

Jan. 12th, 1914, to Feb. 19th, 1914,that I last saw her alive on Feb. 19th, 1914,

and that death occurred on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Septic-Syphilis
(Infection of blood)
(Duration) yrs. ____ mos. ____ ds.Contributory
(Secondary)Pruritic Labor
(Duration) yrs. ____ mos. ____ ds.

(Signed)

Frank J. Gourley, M.D.
Feb. 19, 1914 (Address)

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place _____ yrs. ____ mos. ____ ds. In the _____ State _____ yrs. ____ mos. ____ ds.

Where was disease contracted,
if not at place of death? _____Former or
usual residence: _____

19 PLACE OF BURIAL OR REMOVAL

Newcom Cemetery Feb. 20, 1914

20 UNDERTAKER ADDRESS

Joe. Mattingly Leonardtown

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease

causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc. *Carcin-*

oma

Sarcoma, etc., of _____ (name origin; "Can-
cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chro-
nic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. For example: *Measles* (disease causing death), *29 d.*; *Bronchopneumonia* (secondary), *10 d.* Never report mere symptoms or terminal conditions, such as "Ast-
hma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-
genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Maras-
mus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæ-
mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—acci-
dental*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomencla-
ture of the American Medical Association.)

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RECEIVED

MAR 6 1914

BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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¹ PLACE OF DEATH County: <i>St. Mary's</i>		1936
Village or City: <i>Compton</i>		(No.)
² FULL NAME <i>Infant Walker</i>		
PERSONAL AND STATISTICAL PARTICULARS		
³ SEX <i>Male</i>	⁴ COLOR OR RACE <i>White</i>	⁵ SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>Single</i>
⁶ DATE OF BIRTH <i>Feb 19</i>		(Month) (Day) (Year)
⁷ AGE — yrs. — mos. — ds.		If LESS than 1 day, ____ hrs. OR ____ min. ?
⁸ OCCUPATION (a) Trade, profession, or particular kind of work — (b) General nature of industry, business, or establishment in which employed (or employer) —		
⁹ BIRTHPLACE (State or country) <i>Ned</i>		
¹⁰ NAME OF FATHER <i>Daren Walker</i>		
¹¹ BIRTHPLACE OF FATHER (State or country) <i>Ned</i>		
¹² MAIDEN NAME OF MOTHER <i>Bettie Macnug</i>		
¹³ BIRTHPLACE OF MOTHER (State or country) <i>Ned</i>		
¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (informant) <i>Daren Walker</i> (Address) <i>Compton Compton</i>		
15 Filled _____, 191	REGISTRAR	

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *182*

St. _____ Ward)

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

MEDICAL CERTIFICATE OF DEATH		
¹⁶ DATE OF DEATH <i>Feb 19</i>		(Month) (Day) (Year)
¹⁷ I HEREBY CERTIFY, That I attended deceased from <i>Feb. 19, 1914 to Feb. 19, 1914</i> that I last saw him alive on _____, 1914 and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <i>Stillborn</i>		
¹⁸ LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? Former or usual residence.		(Duration) yrs. mos. ds.
¹⁹ PLACE OF BURIAL OR REMOVAL <i>Newtown Cemetery</i>		DATE OF BURIAL <i>Feb. 20, 1914</i>
20 UNDERTAKER <i>W. C. Macnug</i>		ADDRESS <i>Compton Ned,</i>

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

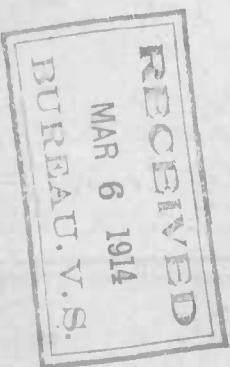
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcio-*

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1 PLACE OF DEATH		1937
County.....		<i>St Marge</i>
Village or City.....		<i>Wynne</i> No. <i>15</i>
2 FULL NAME		<i>Infant Wood</i>
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
<i>Female</i>	<i>White</i>	<i>Single</i>
6 DATE OF BIRTH		7 AGE
<i>June 12</i>		8 yrs. <i>8</i> mos. <i>0</i> ds.
		9 IT LESS than 1 day, <i>0</i> hrs. OR <i>0</i> min. ?
10 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)		
<i>Maraasmus</i>		
11 BIRTHPLACE (State or country)		
<i>St Marge</i>		
12 MAIDEN NAME OF MOTHER		
<i>Lula Tempson</i>		
13 BIRTHPLACE OF MOTHER (State or country)		
<i>St Marge</i>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE		
Informant: <i>Jock Wood</i> Address: <i>Wynne</i>		
15 Filed: <i>Feby 17, 1914</i> By <i>J. O. Klegg</i>		
REGISTRAR		

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH
Registration Dist. No. 280

St; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feby 14, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw him alive on _____, 191____, and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

Maraasmus

(Duration) yrs. *8* mos. *0* ds.

Contributory
(Secondary)

(Duration) yrs. *0* mos. *0* ds.

(Signed) *J. O. Klegg* M. D.
Feby 14, 1914 (Address) *Wynne*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

Wynne DATE OF BURIAL *Feby 15, 1914*

20 UNDERTAKER

Jock Wood ADDRESS *Wynne*

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

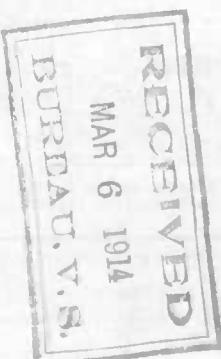
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc.* *Carcin-*

oma, Sarcoma, etc., of _____ (name origin; "Cap-
er" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis* etc. The contributory (secondary or concurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 de.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-
genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture or skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH
County St. Marys

1938

Village or City St. Georges Isld. (No. 11)

189

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 281

St. _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Dunriff Woodland

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female colored</u>	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
-----------------------------	-----------------	--

Single

6 DATE OF BIRTH <u>Aug 2nd</u>	(Month)	(Day)	(Year) <u>1913</u>
--------------------------------	---------	-------	--------------------

7 AGE <u>6 yrs. 6 mos. 28 ds.</u>	II LESS than 1 day, ____ hrs. OR ____ min. ?
-----------------------------------	--

8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>none</u>	(b) General nature of industry, business, or establishment in which employed (or employer) <u>none</u>
---	--

9 BIRTHPLACE (State or country) <u>County</u>
--

10 NAME OF FATHER <u>Frank Woodland</u>
--

11 BIRTHPLACE OF FATHER (State or country) <u>County</u>
--

12 MAIDEN NAME OF MOTHER <u>Birtha Morgan</u>
--

13 BIRTHPLACE OF MOTHER (State or country) <u>County</u>
--

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Alex. Marmaduke</u>
--

(Address) <u>St. Georges Island</u>

15 Filed <u>March 1st, 1914</u> Deputy Local
--

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feby 27 th
(Month) (Day) (Year) , 1914

17 I HEREBY CERTIFY, That I attended deceased from
191 to 191,
that I last saw him alive on 191,

and that death occurred on the date stated above, at 191.
The CAUSE OF DEATH* was as follows:

No Physician

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.
(Signed) Alex. Marmaduke, M. D.
March 1st, 1914. (Address) St. Geo. Island

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place _____ yrs. mos. ds. In the State _____ yrs. mos. ds.

Where was disease contracted,
if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL, OR REMOVAL St. Georges Island DATE OF BURIAL March 1, 1914

20 UNDERTAKER Friend ADDRESS St. Geo. Island

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal pueritis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

APR 6 1914

BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH
County *St. Mary's*

1939

Village or City *Lionardtown* No. *1*

2 FULL NAME *Eduoard Moyer*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Male</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>Single</i> <small>(Write the word)</small>
-------------------	------------------------------	--

6 DATE OF BIRTH *September 1*
(Month) (Day) (Year)

7 AGE *60* yrs. — mos. — ds. If LESS than
1 day.....hrs.
OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work. *Farm Laborer*
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country) *St. Mary's Co*

10 NAME OF FATHER *Unknown*

11 BIRTHPLACE OF FATHER
(State or country) *Unknown*

12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER
(State or country) *Unknown*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Dr. Martin, Dupt*

(Address) *St. Mary's Hospital*

15 Filed *Jan 10, 1914* *Lionardtown* *J. J.*

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *283*

St.: Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Feb 4*, 1914
(Month) Day (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Jan 29th*, 1914, to *Feb 4*, 1914, that I last saw him alive on *Feb 3rd*, 1914, and that death occurred on the date stated above, at *2 p.m.* The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(Duration) — yrs. — mos. — ds.

Contributory *unknown*
Secondary *unknown*

(Duration) — yrs. — mos. — ds.

(Signed) *J. J. Gwynnell, M.D.*
Aug 10, 1914. (Address) *Lionardtown*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence:

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sacred Heart Cemetery *Feb 5th, 1914*

20 UNDERTAKER ADDRESS

Joe C. Mattingly *Lionardtown*

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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